*Subject to approval by the Task Force*

# HEALTH CARE TASK FORCE
# MINUTES

Friday, December 9, 2005
9:00 a.m.
JFAC Room, State Capitol
Boise, Idaho

The meeting was called to order by **Cochair Representative Bill Deal** at 9:10 a.m.. Other committee members present included: Cochair Senator Dean Cameron, Senators Joe Stegner, John Goedde, Tim Corder and Kate Kelly, and Representatives Max Black, Gary Collins, Sharon Block, Kathie Garrett and Margaret Henbest. Senator Dick Compton was absent and excused. Staff members present were Caralee Lambert, Cathy Holland-Smith and Toni Hobbs.

Others in attendance included: Mike Brassey, St. Luke's Regional Medical Center; Director Gary Smith, Joan Krosch, Donna Daniel, Eileen Mundorff and Shad Priest, Department of Insurance; Tim Olson and Norm Varin, Regence BlueShield of Idaho; Steve Tobiason; Linda LaMott, Idaho Association of Health Underwriters; Molly Steckel, Idaho Medical Association; Kate VandenBroek, St. Alphonsus; Woody Richards; Steve Millard and Bonnie Haines, Idaho Hospital Association; John Watts, Veritas Advisors; Scott Pugrud and Skip Smyser, Connolly and Smyser LTD.; Representative Nicole LeFavour, District 19; Suzanne Schaefer, SBS Associates, LLC.; Tom Bassler, Blue Cross; Leslie Clement, Medicaid and Representative Bob Ring, District 10.

On a motion from **Senator Corder** and a second from **Senator Goedde**, the minutes from the last meeting were approved by a voice vote.

**Mr. Shad Priest,** Department of Insurance, was introduced to give a presentation regarding the determination of insurance rates. This complete presentation is available at the Legislative Services Office. **Mr. Priest** explained that in Idaho there are three categories of health plans for rating purposes. These are: (1) large group (more than 50 employees); (2) small employer (2 to 50 employees); and (3) individual.

**Mr. Priest** noted that in Idaho, there is no rate regulation for health insurance plans issued to large groups. Small employer rate regulation is covered in Chapter 47, Title 41, Idaho Code. He noted that the purpose of rate regulation for small groups, as stated in the statutes, is to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group market. It is <u>not</u> intended to provide a comprehensive solution to the problem of affordability of health care or

health insurance.

**Mr. Priest** said these statutes were enacted in 1993 based upon a National Association of Insurance Commissioners (NAIC) model law that has been adopted in over half of the states. The law was intended to promote more fairness and availability of insurance to unhealthy people.
The NAIC model law has been amended over the years, but Idaho has not incorporated many of this amendments. This means that Idaho is operating under an earlier version of the law.

**Mr. Priest** continued by explaining that there are three types of rate regulation in the small group area (*see* 41-4706, Idaho Code) as follows: (1) Restrictions on differences in rates between classes of business; (2) Restrictions on rates within a class of business; and (3) Restrictions on rate increases. He said the underlying idea has been to encourage a spreading of risk, so small employers with healthy employees will subsidize, to a certain extent, small employers with less healthy employees. The result is that some small groups may pay more for health insurance than they would if there was no spreading of risk.

**Mr. Priest** explained that a class of business is a grouping of small employers made by a carrier to reflect substantial differences in expected claims experience or administrative costs due to:
- Differences in systems for marketing and sale of the plan;
- The group of small employers was a class of business acquired from another carrier; or
- The class is made up of an allowable association group.

A carrier is allowed up to nine separate classes of small employer business. The Director of the Department of Insurance may approve additional classes to promote efficiency and fairness in the market. **Mr. Priest** said he did not think that any carrier in Idaho had this many classes of business and noted there have not been many issues with respect to the classes. Essentially, the law states that if classes of business are used for rating purposes, the index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20%, with those terms defined as follows:.
- Index Rate = The arithmetic average of the applicable base premium rate (lowest premium rate) and the corresponding highest premium rate.
- Rating Period = The calendar period for which premium rates established by a small employer are assumed to be in effect.

**Mr. Priest** said Idaho does not have any restrictions on rating periods, meaning there could be a one-month rating period, but rating periods are typically considered to be for one year.

**Mr. Priest** then discussed rate restrictions within a class of business. He stated that at least 47 states have adopted rate bands or some form of “community rating” to regulate premium rates for health plans offered to small employers. Idaho is among the 38 states that rely on rate bands. Under community rating, health premiums are established by looking at the total expected use of services for all small employers within a particular geographic region, rather than rating the small employer groups individually. In pure community rating, all small employers in the group

would pay the same amount of premium regardless of individual characteristics. Modified community rating allows limited differences in amounts charged to the small employers that are grouped together to reflect expected differences in use of covered services.

In Idaho, the premium rates charged for a class of business during a rating period to small employers with similar case characteristics for the same or similar coverage cannot vary by more than 50% of the index rate. Case characteristics are objective characteristics of a small employer group considered by the carrier in establishing a premium rate. Unless otherwise approved by the Director, the only case characteristics that may be considered are: age, tobacco use, geography and gender. The highest rate a carrier can charge a small employer may not be more than three times the lowest rate offered to small employers in that class of business with similar case characteristics. Fifty percent is the largest spread for states using rate bands; most are 25%.

**Mr. Priest** explained that Idaho used 25% rate bands until 2000, when the law was changed to expand that to 50%. The goal was to allow carriers to drop their rates and bring more healthy groups into the market. The same thing was done with respect to individuals. By bringing these healthier groups in through lower premiums, the goal was to strengthen the market and bring rates down for everyone. This was the same year the high risk pool was established and age bands were changed from five years to one year.

**Mr. Priest** said that any attempt to compress rates results in increased costs to some people. Healthy people end up paying more and less healthy people pay less than they would if they were rated completely on their own. This is a policy decision that legislatures have made to say they think it is more fair to spread the costs rather than allowing unhealthy groups to be priced out of the market.

**Mr. Priest** stated that the small employer restrictions on premium rate increases is the area for which the Department receives the most complaints and inquiries. Section 41-4706(1)(c), Idaho Code, says that the percentage change in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

- The percentage change in the new business premium rate measured from the first day of the new rating period; plus
- Any adjustment not to exceed 15% annually due to claims experience, health status or duration; plus
- Any adjustment due to change in coverage or change in the case characteristics of the small employer.

In addition to these requirements, **Mr. Priest** discussed a number of miscellaneous requirements for small employer insurance, including the requirement that rating factors must be applied consistently within a class of business, plans issued or renewed in same month must be treated as using the same rating period, and carriers must make certain disclosures regarding rates in their marketing materials.

In response to a question from **Representative Black**, **Mr. Priest** said that carriers tend to price new business lower. The longer someone is with an insurance carrier, the more likely they are to have claims experience. It is his understanding that some carriers rate based on the period of time a person is with the carrier.

**Representative Henbest** asked how the maximum of 15% increase compares with other states. **Mr. Priest** said the 15% is NAIC model language and that standard is used by most states. **Representative Henbest** asked what the amendments to the NAIC model law have looked like in other states. **Mr. Priest** said that many state legislatures have amended the model act. **Ms. Joan Krosch,** Department of Insurance, explained that the Idaho act is based on the 1991 NAIC model for small employers. In 1995, that NAIC model was updated to move toward community rating. Pursuant to the Idaho model as developed in 1991, carriers use underwriting practices and age bands to determine premiums. Under the 1995 model, an adjusted community rating based more on the overall was used find a rate that would be applied to an entire group. **Senator Cameron** suggested that a review or outline of how Idaho's statutes are different from the current NAIC model would be helpful to the committee.

**Senator Cameron** noted that the biggest area of complaints are based upon premium rate restrictions. He said this is somewhat involved due to different interpretations of the law between carriers. When the law was passed, the 15% trend was thought to be more of a controlling factor than it actually is. The dilemma is in the interpretation of what "trend" is. Often trend is interpreted differently, even within the same carriers. He asked if Idaho needs to clarify what trend means and make that understandable to carriers. **Mr. Priest** said that this is an issue throughout all of the states and the NAIC. **Ms. Krosch** said that the overview **Senator Cameron** requested will give a lot of information. She said 1991 is when Idaho took the first step at small group reform. In 1995, the NAIC adjusted this model and Idaho has not updated its provisions to match those adjustments. Some of these updates were done in an effort to address some the marketing and other issues that had occurred based on the earlier model.

**Senator Cameron** asked if expanding the rate bands to 50% helped rates go down to healthy groups or whether it just allowed carriers to charge more for unhealthy groups. **Mr. Priest** said that information was included in the benchmark study. He does not think rates have gone down for anyone, but the question is whether they went up less because of rate band expansion. The small group market has seen some increases, but it is difficult to know if that is a result of Idaho's growth or due to groups being covered that would not have had coverage before the rate band expansion. **Ms. Krosch** agreed. She said it is difficult to know exactly what has happened. Expansion probably brought in new business, but the data is not available to answer that exactly.

**Senator Corder** asked if there is a need for the Legislature to define trend. **Mr. Priest** said that the term does need some refining. An analysis of what is happening in other states and with NAIC law will show this.

**Senator Corder** asked what information is needed to find out if the rate band expansion helped. **Mr. Priest** said it is difficult to evaluate profitability of Idaho's two largest carriers because they

are nonprofit and there are other market factors involved besides rate bands. He said the Department has not done a review since these laws were changed to determine whether the carrier's surplus has gone up or down. **Senator Corder** commented that this is an important piece of information and there needs to be a way to see if the rate band expansion worked.

In response to another question from **Senator Corder** regarding who decides what the rating period is, **Mr. Priest** said that it is based on the plan the consumer chooses. Each plan specifies the rating period.

**Senator Cameron** said some people have suggested that carriers should be required to file their rates and receive approval from the Department prior to offering a product. He said other states do this. He asked for the Department's opinion. **Mr. Priest** said that the Department does not have an actuary on staff, so that work must be contracted out. In his opinion, prior approval would not help bring down health insurance rates in Idaho. Currently, the Department can go back and if it finds that a carrier is not in compliance, it can be required to refund consumers the amount of overcharges. Prior approval also causes delay in getting products to market.

**Mr. Priest** commented that the Kaiser Family Foundation website at statehealthfacts.kff.org includes state comparisons on an array of health-related issues including insurance premium costs. Idaho rates ranked about 40th. He said Idaho's rates are not bad compared to other states partly because Idaho has fewer mandated benefits.

**Mr. Priest** discussed rate regulation for individual health plans. He explained the purpose of Chapter 52, Title 41, Idaho Code, is the same as for small employer insurance and it is also not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance. There are 50% rate bands as well as limits on rate increases. There is also a requirement for actuarial certification on or before Sept. 15 that the carrier is in compliance with Chapter 52 rating requirements.

In response to a question from **Senator Corder**, **Mr. Priest** said that rate bands for individual coverage changed at the same time as for the small group. He noted that it is somewhat easier to identify high-cost versus low-cost individuals, but the same problems exist in being able to tell if the rate band expansion worked because of different coverage and other factors.

**Senator Kelly** asked whether other states regulate large groups. **Mr. Priest** said he was not aware of other states that regulate large group. Many large groups are self-insured. **Ms. Krosch** said she would include this information in the review of states **Senator Cameron** requested.

**Senator Cameron** commented, regarding a slide in **Mr. Priest's** presentation showing average annual percent growth in personal health care expenditures, that he had always wondered why Idaho's trend rate is higher than other states. He asked if there have been any studies done regarding this. **Mr. Priest** said he found this slide interesting because it ranks Idaho among the top of states with respect to percent growth in personal health care expenditures and Idaho is actually near the bottom in terms of actual dollars spent. He said he did not know if there is any

correlation between this and the fact that Idaho's trend seems to be higher than the national average every year.

The next item for discussion was proposed legislation RS15355 dealing with self-funded health care plans or multiple employer welfare arrangements (MEWA). Department of Insurance **Director Gary Smith** was introduced to discuss the legislation. He explained that a MEWA is a term that was created in the federal employee retirement income security act (ERISA). This definition of a MEWA includes an employee welfare benefit plan or any other arrangement that is established or maintained for the purposes of providing benefits to the employees of two or more employers. MEWAs can come in two forms: insured or self-funded. If a MEWA chooses to be fully-insured, the Department would regulate the insurer, not the MEWA. If a MEWA chooses to self-fund, it essentially acts as the health insurer to its employees by paying for health benefits from the amounts collected from the employees along with the employer contributions. In this case, the Department would regulate the MEWA under Chapter 40 of Title 41, Idaho Code. Self-funded plans also generally cover part of their risk through a stop-loss insurance policy. MEWAs are subject to some federal reporting requirements under ERISA law.

**Director Smith** continued by stating that in 2001 the Legislature amended Chapter 40, Title 41, Idaho Code, to exclude from application any plan administered by or for any county of the state. This amendment was made at the urging of a few large counties that wanted to provide self-funded single employer health care plans for their employees without having to meet the requirements of Chapter 40. At the time this amendment was passed, there was never any debate or contemplation that it would apply to self-funded multiple county plans.

**Director Smith** said that due to the fact that these multiple self-funded plans compete with and are generally marketed in the same way as regular insurance plans, and because a single failure can impact many employers and hundreds of families, the Department feels these plans should be held to the same level of scrutiny as other types of health insurance and that they must comply with the same regulatory requirements. Some of those regulatory requirements would include that they be registered with the Department and, if they do not register, they would be considered to be transacting insurance without a license in the state. The Department would require that all contributions be paid in advance and be deposited and held in a trust fund under a trust agreement that has been reviewed and approved by the Department. As trustees of the plan, they would be required to provide a written statement or schedule to all beneficiaries that adequately and clearly states all benefits currently being allowed, along with all restrictions, limitations exclusions, and the procedures for filing a claim. The Department would determine that these plans were actuarially sound and maintain reserves for claims, including claims incurred but not received in an amount certified as adequate. They would also be required to pay a four cent per month, per beneficiary tax to the Department.

**Director Smith** said while his personal views are for consumer choice and competition in the marketplace, the overriding concern here is about safety and soundness and that all health plans in Idaho be registered within the Department and have the resources to pay benefits. He emphasized that this legislation is not about the Gem Plan; it is about MEWAs. He added that

the Department does consider the Gem Plan to be a MEWA.

**Director Smith** said the Department is concerned about MEWAs because, unlike a registered health care plan, there is no guaranty association for persons covered by a self-funded plan. Self-funded multiple employer plans are often marketed to employers as being the equivalent of insurance. Aggressive marketing, combined with unrealistically low premiums, initially allow MEWAs to expand quickly. Unlike single employer plans, this ability to easily attract new members with the low rates allows MEWAs to generate large amounts of cash very quickly. This stream of cash allows MEWAs to pay current claims with premiums collected from new members rather than setting aside those moneys in reserve for future claims. He said this strategy works fine as long as there is a constant flow of new members and new cash. Employers who sign on with these plans must rely solely on the competence and integrity of the plan operators and often out-of-state third party administrators to handle the premium funds responsibly and to process and pay the claims. **Director Smith** said that many employers who sign on with these plans often believe they are purchasing a traditional insurance produce that has oversight by a regulatory agency. Under Idaho law today, that is simply not the case.

**Director Smith** said that as a result, the Department has taken the position that MEWAs should be regulated in the same manner as all other insurers. He said it is critical to clarify this in Idaho Code. He concluded by stating that the issue is not just dealing with employer funds or, in the case of the Gem Plan, with taxpayer funds being placed in jeopardy. This also involves the consumers who are paying their premiums and feel like they have health insurance. If a MEWA were to go insolvent, these consumers would be left without health insurance, they would lose all the money they have paid for premiums and, in many cases, they would be personally liable for unpaid medical bills. This happened with a plan in the Coeur d'Alene area.

**Senator Goedde** asked how this legislation will affect counties that are self-insured now. **Director Smith** said it will not affect them at all because they are fully compliant. He said there is a large difference between a single county being self-funded and having multiple counties in the same plan. **Representative Deal** commented on an Idaho Statesman article that discussed a California plan that is in default because it was not properly funded.

**Representative Black moved that Task Force forward RS15355 to the Business Committee for consideration. Senator Goedde seconded. The motion was approved unanimously by voice vote.**

**Mr. Tim Olson**, Regence BlueShield, was introduced to discuss draft legislation dealing with HIPAA compliance. **Mr. Olson** said that in 2003, the Regence group (a multi-state association) was given the task to look at areas where the health care system could be made simpler and more efficient with the intent being to reduce the cost of the administrative side of health care. It was noted that three of the four states in the association had the ability to discontinue outdated products during the regular course of business. With further research, they found that nearly 40 states in the United States have this privilege to address outdated products.

**Mr. Olson** stated that multi-state employers want a consistent application and it is felt that removing this barrier in Idaho may encourage other carriers to look at Idaho as a place to do business. Having outdated products on the books adds to the administrative cost that is borne by others who are purchasing insurance in open products. He said the Regence is not aware of any problems that have resulted from this language in other states. It is his understanding that the Department did not find any problems that had occurred as a result of the language, and the language has been approved by the Idaho Association of Health Plans.

**Senator Cameron** asked for **Mr. Olson's** interpretation regarding the intent of the legislation and how long a carrier should be required to carry a certain block of business on their books. **Mr. Olson** compared requiring insurance companies to carry outdated products to requiring companies to continue to produce outdated typewriters or cars. He said Regence has a product that has been on the books for a number of years with one person on it. The cost to maintain the infrastructure to keep that product alive for that one person is expensive and the cost is shared by all policy holders. That has an impact on the cost of administration. Other partners in Regence in other states do not have that problem; they are able to react to the marketplace quickly by not having that added administrative cost burden. **Senator Cameron** said that in his opinion, this is not the same as buying a car or a typewriter. People choose insurance products because they want those benefits. He asked what the intent of the legislation is and whether it allows a carrier to decide to completely discontinue a product the day after it decides not offer it. **Mr. Olson** said what Regence is asking for is no different than what 90% of the other states are doing.

**Senator Cameron** said that in reading the legislation it seems to say that under current law an insurance company is required to renew a group except, under the new language, if the carrier elects not to renew a group. The new language also seems to say "or if the carrier determines to modify a group." **Mr. Norm Varin**, Regence BlueShield, said that this proposed legislation, in the event that a carrier deems that a product is outdated and cumbersome to administer and it no longer provides a benefit for most of the population, provides protection to those groups and individual members in that product. If that benefit option is discontinued or modified, the legislation allows them to purchase any other benefit option offered by that carrier. They must be notified 90 days before the discontinuation or modification.

**Senator Cameron** said he understood the explanation but was still unsure as to the actual intent, e.g. is it to be able to drop a group from the moment the carrier decides not to offer a product after giving 90 day notice? **Mr. Varin** said that is not the intent. The intent is to let customers know what is happening to the product and if the customer does not notify the carrier of what product they want, the carrier will put them in next closest product offered. The intent is not to be able to drop a group. **Senator Cameron** said in his opinion the legislation does not say that. Laws exist that guarantee renewability, and this legislation says there is guaranteed renewability unless the carrier decides not to renew. He said he does not think that is their intent. **Mr. Varin** said this language is standard HIPAA language that other states are using. He noted that Regence in Oregon transferred 50,000 customers through this process.

**Senator Cameron** suggested that the legislation needs more revision before the Task Force can

vote on it. He said this is a public policy decision. Currently, Idaho law says carriers are required to continue a block of business or a product even though it is outdated. At some point, this is probably not feasible or cost-effective to continue. He had hoped the legislation would identify at what point a product is no longer effective or feasible. In his opinion, the draft is too wide open and could allow carriers to use it inappropriately.

**Mr. Olson** commented that this legislation is very important to Regence and they want to make sure that is goes forward in some form. **Representative Deal** suggested that **Mr. Olson** meet with Task Force members to clarify the legislation.

**Representative Black** asked whether a product that has been issued can be modified in any respect under current law. **Mr. Olson** said yes, with the involvement of the Department. **Mr. Priest** said that Idaho has guaranteed renewability. If a carrier wants to modify a plan, the Department looks at the plan to see if a change is beneficial or whether it will be questionable by consumers. The Department has allowed changes. Significant changes are not allowed. He said this legislation seems to move away from guaranteed renewability. In his opinion, this legislation would allow a carrier to stop offering if certain notice is given.

**Senator Stegner** was introduced to discuss RSCAL351. He explained that this is just "housekeeping" legislation. When the high risk pool was implemented, it was supposed to have a joint oversight committee. This legislation makes that oversight committee the Health Care Task Force. **He moved that the draft be forwarded to the Legislature for consideration. The motion was seconded by Senator Goedde.**

In response to a question from **Representative Garrett, Senator Stegner** said he would change the legislation to say that the Health Care Task Force has six members from the Senate and six members from the House of Representatives.

**The motion carried unanimously by voice vote.**

**Senator Cameron** said the legislation was important and suggested that it start in the House this session. **Representative Deal** agreed.

**Representative Deal** commented that he and **Senator Cameron** had met with members from the Community Health Clinics to discuss the issues and recommendations they presented to the Task Force at an earlier meeting. In light of some of the proposed reforms being considered, it was decided to withdraw those ideas until a later date. **Senator Cameron** said they would be invited to the next meeting to present. He said they wanted to be helpful in allowing people to obtain health insurance coverage. He said the clinics did not want to be seen as trying to compete with any of the reforms being considered in the Governor's Medicaid reform package.

**Representative Rusche** commented that he would have more information regarding the Health Data Authority legislation for the Task Force at the next meeting.

**Senator Corder** said there still needs to be clarification regarding whether the expansion of rate bands was successful. He said there has been legislation dealing with removing rate bands altogether and in his opinion this needs more discussion. He said there is also the issue of defining "trend". Representative Deal suggested that these topics be included in the next meeting.

**David Rogers**, Department of Health and Welfare, was introduced to discuss proposed Medicaid reforms. His complete presentation is available at the Legislative Services Office. **Mr. Rogers** said that he believes Idaho has the opportunity to contribute greatly in the national debate on what should happen with Medicaid. He said this is an opportunity to do a better job for the 180,000 individuals that the Medicaid program serves. He stated that his presentation is the result of a proposal by the Governor, and noted that the plans are not set in stone

**Mr. Rogers** explained the reform is necessary because Medicaid is unsustainable in its existing form. Access, quality, and cost containment must be balanced. There is also the need for more flexibility on the federal level to take some fundamentally different approaches to Medicaid. Decision-making questions include: Is the change holistic? Does the change foster simplicity? Does the change promote fairness? Does the change create value?

According to **Mr. Rogers**, characteristics of the existing Idaho Medicaid programs include a program administration focus versus an outcomes focus and a system that is based on rules rather than health needs. In addition, current eligibility categories do not describe health needs; the eligibility structure results in cost controls without regard to health needs with a "one size fits all" approach. **Mr. Rogers** said that there are about 30 eligibility categories in federal law that do not do anything to describe an individual's health needs. When someone needs Medicaid assistance, they are asked how poor they are, not what their health needs are.

**Mr. Rogers** explained that low-income (non-disabled) children and adults make up 73% of enrollees but account for only 32% of expenditures. The lack of flexibility in benefit design gives healthy children essentially the same benefit package as children with disabilities or special health needs. Existing benefit packages do not encourage responsible use of health care services.
Wellness and prevention are not promoted.

**Mr. Rogers** said the approach to modernizing Medicaid is the result of being asked what they would do if they could start over with Medicaid. The approach includes:

- Simplify eligibility to match identified needs.
- Establish policy goals relevant to specific populations.
- Modify benefits to meet identified needs and promote policy goals.
- Alter delivery systems to efficiently and effectively meet needs and program goals.
- Match quality and performance improvement to population served.

The proposed modernization would divide the Medicaid program into three distinct Medicaid plans: (1) Low-income children and working-age adults; (2) Individuals with disabilities or

special health needs; and (3) Elders.

**Mr. Rogers** said the managed care contracting or selective contracting which is the federal terminology could be described as managing the network or placing reasonable restrictions on the network. This includes short term items such as durable medical equipment involving such things as incontinence supplies. This would allow them to take advantage of the opportunity to get better pricing for services that are currently covered by focusing the purchasing power on a limited number of suppliers. He said they have also proposed to do some selective contracting in the area of transportation. This is referred to in Medicaid circles as transportation brokering. They also plan to outsource dental services and to look at the rate structure to improve access without a significant increase in public expenditures.

With regard to pay for performance, **Mr. Rogers** said this will involve making sure children receive immunizations and will include a pay for performance system for chronic conditions such as asthma and diabetes. This is an approach to disease management allowing providers additional reimbursement if they receive better outcomes. Today, the provider is paid the same monthly management fee regardless of the care they provide.

**Mr. Rogers** continued by stating that it is important to do some type of reinvestment of the cost containment within the proposal to spur the growth of health information technology within the broader system. There are a variety of options being considered and it is expected they will take the form of grants or incentives that will allow private practitioners to make that investment. He said they have been working with both the residency programs and community health centers.

**Mr. Rogers** explained that policy goals for low income children and working-age adults include: (1) Emphasize preventive care and wellness; (2) Increase participant's ability to make good health choices; and (3) Strengthen employer-based health insurance. Eligible participants in this group would include pregnant women & children ("PWC") (133% FPL); TANF-related, CHIP A (150% FPL),CHIP B (185% FPL), small business employees (185% FPL limted to 1,000 adults); and other mandatory groups. The benefits design at a high level would mirror private insurance and would not include long-term care services. The benefits design will also look to mirror mental health benefits offered by private insurance. He said this is thought to be consistent with the direction they received from the legislation last year. The benefits design will also focus on: (1) Increased prevention services; (2) Enforceable cost sharing; and (3) Expanded premium assistance. **Mr. Rogers** stated expanding the premium assistance is a critical part of the proposal due to the potential for cost containment within the Medicaid program.

The policy goals for individuals with disabilities or special health needs are to empower the individuals to manage their own lives and to provide greater opportunities for employment. The benefits package would mirror current Medicaid coverage and expand self-determination options for individuals with disabilities to give them more control over their long-term care services and increase the use of work incentives.

Policy goals for elders include: (1) Improve coordination with Medicare coverage; (2) Increase

non-public financing for long-term care; and (3) Ensure dignity and quality of life. Eligible participants would include all eligible individuals over 65 years who are covered by Medicare. Individuals with disabilities who are also covered by Medicare would have the option of electing this benefit coverage. The benefits design would focus on: (1) Increased caregiver support; (2) Long-Term care options counseling; and (3) Medicare excluded drugs (and related services).

In response to a question from **Senator Corder** regarding the use of reverse mortgages as a long-term care tool, **Mr. Rogers** said the Department has received a federal grant from the Centers for Medicare Services (CMS). The purpose of that grant was to establish aging resource centers and disability resource centers that provide the long-term care options counseling. He said there is a lot of work to be done and based on preliminary research, there may be some code changes required to make reverse mortgages easier for people to get.

**Senator Kelly** ask if this proposal is available in writing or accessible to the public. **Mr. Rogers** said there are two documents. One is a concept summary that has been published by the Governor's Office. This is available at modernizemedicaid.idaho.gov. He said there is also a document the Department has been using in working with federal partners that has essentially the same content but is much more technical in describing the eligibility requirements.

**Senator Kelly** asked for the time frame for implementation of the plan. She said the concepts are helpful but she would like more information. **Mr. Rogers** said they do have a working timeline being used internally as to how the additional research is getting done and what dialogue needs to happen at the state and federal levels. The Governor hopes to have federal approval this spring and to implement changes in July of 2006. The approach is to share the details with CMS as they develop. Florida used this approach and they received approval from CMS 16 days from the time that state submitted its potential waiver request.

**Representative Block** asked how they plan to implement the program in regard to Idaho Code. **Mr. Rogers** said they look forward to working with the Health and Welfare Committees regarding those statutes and administrative rules.

Regarding **Mr. Rogers**' comment about healthy kids and mental health services that look similar to private commercial plans, **Representative Henbest** said that the mental health subcommittee looked at what is covered in Idaho and has found this does not offer a good safety net for kids with mental health issues. She asked if this new plan will take benefits away. **Mr. Rogers** said the intent is to reshape the benefit. He said there are situations where mental health services are being used as daycares under Medicaid.

**Representative Garrett** said the mental health subcommittee has been looking at diagnoses and would like to have input on how "serious emotional illness" is defined and what categories of services are going to be offered. **Mr. Rogers** said he welcomed that and noted the Department needs to be responsive to the subcommittee and the work they have done.

**Senator Cameron** said he realized many of these issues are conceptual in nature right now and

applauded the Governor and **Mr. Rogers** and his staff for dealing with this difficult issue. He agreed that Medicaid cannot be sustained as it is currently structured. If nothing is changed, in 13 years the state will be spending more on Medicaid than on public schools. He said he likes and agrees with the concept of trying to find out health conditions or doing a health risk assessment when children initially enroll in Medicaid. He asked what the Department will do with the information gathered from the proposed health assessments and whether the focus will be on preventive care for those children that are healthy or only on the children with problems. He also asked whether the Department has envisioned how often an assessment will be done. **Mr. Rogers** said that the assessment includes definitive triggers that will let them know if a child has special needs. The assessment also includes gathering information on behaviors (obesity or other risk factors) so those can be addressed. Information regarding the child's health status will be used by the Department as outcome measures over time on an individual basis and as a population of Medicaid beneficiaries. He said they propose to do the assessments at least annually in the same way they look at financial eligibility.

**Senator Cameron** said that copays, if done right, can effectuate change and direct traffic to the best and most cost-effective place of care. He said this process is not only about saving money but also about providing better treatment and getting better outcomes. He noted that the method of collecting the copay can be counterproductive, as has been seen in some states. He asked what the Department's philosophy was regarding who will collect the copayment and how it will be administered. **Mr. Rogers** said the answer differs by the type of copayment. In some areas, such as emergency transportation, that adjustment has already been made and they feel that impact in their claims. He said this mechanism would need to be developed to direct that toward the individual after the Department has made the determination as to whether the service was appropriate. Inappropriate use of emergency rooms as determined by the Department would result in the hospital being responsible for collecting that copay from the individual. He said there has been some concern about payment rates and how copays affect payment rates. **Senator Cameron** said he would be cautious about requiring a provider to collect a copayment and then reducing their reimbursement rate. In his opinion, that would cause additional cost-shifting.

**Representative Block** asked about the proposal's projected budget impact. **Mr. Rogers** said he can give some idea but is cautious because it is dependent upon the copay amount. He said the way to look at this is to look at what the Medicaid growth rate would be if nothing is done for each population and what the growth rate will be with the reforms. He said the Department expects to see that reforms will make a difference specifically in the low-income children and working-age adults population. He said they are projected to spend $90 million on the mental health benefits package this year.

**Senator Stegner** was introduced to give the mental health subcommittee report. This complete report is available at the Legislative Services Office. **Senator Stegner** said the priorities the subcommittee has identified include consideration of trying to achieve a sustainable increase in service delivery for mental health without overstepping. Other recommendations include early intervention services. This involves the Community Resource Workers (CRW) program. This has existed in the public schools for 10 years. At one point this was funded entirely by the

federal government and as many as 93 school districts participated in the program with as many as 110 CRWs working statewide. When the federal money ran out, the state took over more responsibility and asked the school districts to participate in the cost. That has led to an erosion of the program.

**Senator Stegner** said there have been a number of efforts to try to revitalize the CRW program in the Legislature in the last few years. The subcommittee feels there is broad support for this early intervention program in the public schools and that there is significant room for expansion of the program. It would not be an expansion of scope, but rather an incentive for school districts to increase participation by decreasing the amount school districts have to pay to 25%. Currently they are required to pay 66% of the cost. The subcommittee also recommends that the program be expanded from kindergarten through junior high. **Senator Stegner** said the subcommittee did not think the proposal would require additional or new funding because through intent language there is currently a $2 million annual appropriation using TANF funds for this purpose. The amount expended for that purpose in 2004 was $332,000; in 2005, it was $216,000; and currently, for this fiscal year, only $17,000 has been used for that purpose.

**Senator Cameron** said he has been involved in discussions regarding the CRW program since the federal funding started drying up. It has, at times, been very contentious. He asked what the mental health benefit was to continuing the CRW program; *i.e.* is it being driven by those who are providing the service or by an actual outcome that would benefit children? **Representative Henbest** stated that schools value the program but there was a question of whether that was their role. This is a benefit from a social resource and mental health standpoint to the child and family, which is different from the educational goals and responsibilities that schools have. Separating that out and placing a value on that from the Health and Welfare standpoint is important. She said placing this entirely in education seems to be misplaced. As the subcommittee asked questions about the function CRWs provide, it was discovered that CRWs provide children with social resources that help them learn, including emergency housing or food assistance.

**Senator Cameron** said he had not heard much about the CRW program from rural school districts, parents or community service providers. More is heard from larger school districts who were using program. Many districts said they would rather have the money as discretionary funds. **Representative Henbest** said that mental health is one of the reasons the subcommittee felt it was important to expand the CRW program into junior high. This is a more typical time for mental health issues to appear. CRWs could make the appropriate referrals to allow early detection and intervention. **Senator Stegner** commented that the subcommittee studied increasing the scope of community workers to include specialized mental health detection and substance abuse and treatment. He said the subcommittee would like to see this program eventually go in that direction. **Senator Corder** commented that the entire subcommittee was in agreement with all of the recommendations made. He said there is a gaping hole for detection of mental health issues for children. He said that in one rural school district, they had a lightly funded agency that initially used 20% of their budget for prevention or detection and 80% went to remediation or correction. After a short time, the budget turned over and now only 20% of their budget is being used for remediation or correction. He said if the state can be successful in

identifying the needs of young people, the trend can be reversed and these people can be prevented from ending up in the correction system. He said this should be the ultimate goal.

In response to a question from **Representative Block** regarding similar resources available in the Department of Health and Welfare, **Senator Stegner** said the subcommittee did not look for other resources because there is a funding source available for this already. The program is already allocated and is being underutilized. **Senator Cameron** asked what the additional cost would be. **Senator Stegner** said costs could be controlled on a "first come/first served" basis. **Senator Cameron** asked, assuming this $2 million is not being used anywhere else, how many districts that would help. **Cathy Holland-Smith,** Budget and Policy Office, stated that in 2005, 13 school districts utilized the program and with the change that could be doubled. **Senator Cameron** asked what the TANF money is currently being used for. **Ms. Holland-Smith** said she would get that information for the Task Force.

**Senator Stegner** said the next recommendation of the subcommittee was mental health parity for state employees. He said this is not a mandate of insurance coverage for state employees; it is simply a pilot project using one of the largest groups in the state to try to identify whether or not there is a significant state benefit to having parity status for mental health services comparable to other health services. It would have a sunset of three years and would be monitored and evaluated by the Legislature. The evidence the program generated would be used to determine whether it is in the best interest of the state to expand this. He said they estimated the cost of implementation to be $1.9 million.

**Senator Stegner** explained that another subcommittee recommendation was to develop additional services on a regional basis using regional mental health boards. He said this concept was successful last year in distributing additional ACT teams that were approved by the Legislature. The subcommittee recommends the addition of 7 more ACT teams at a cost of $3.86 million, realizing that the administration is asking for one ACT team. The need is great and in the opinion of the subcommittee, these teams are the single most beneficial tool available to impact the emerging mental health court system.

**Senator Stegner** continued by stating that the subcommittee also recommends providing incentive grants to communities to develop services on a regional basis. Services that could be funded would be transitional housing and increasing psychiatric beds and emergency beds in the regions. These services would be part of the Cooperative Service Plan component provided for in Section 39-3134A, Idaho Code. The dollar amount for these grants has not been determined.

**Senator Cameron** asked if the subcommittee discussed grants or low-interest loans. He agreed that there needs to be incentives for transitional housing, but he has heard that there are organizations that would be willing to offer this if the government would reimburse them for the costs. **Senator Stegner** said the subcommittee did not discuss that.

**Senator Stegner moved that the Task Force accept the subcommittee's report and forward the recommendations on to the appropriate germane committees.**

**Senator Cameron** said he had no objection to the other recommendations but that he needs more information on the CRWs. **Senator Stegner** said the subcommittee would like to have all of the recommendations considered by Legislature. He said he realizes that not everyone is going to agree with the entire package, which is why he made the motion to forward the recommendations on to Legislature. Doing this does not tie the hands of anyone to support final legislation. He said it is not going to be easy for all of these to pass the Legislature but that even if none pass, the idea that mental health issues need a higher priority in the state will be passed on.

**Representative Henbest seconded the motion and the motion carried by a unanimous voice vote.**

The meeting was adjourned at 3:30 p.m. Representative Deal noted that the Task Force will plan to meet in the second or third week of the 2006 session.